

ROTHMAN
INSTITUTE

Orthotic Department - 825 Old Lancaster Rd., Suite 200, Bryn Mawr, PA 19010
800-321-9999

PATIENT DELIVERY FORM

Patient Name: Ezekiel Sennard Date of Birth: [REDACTED]

Account Number: [REDACTED]

Orthotic device dispensed [REDACTED] 11-0688-2

Right / Left

L-Code: [REDACTED]

DRYTEX, PLAYMAKER, WRAPS

Disclaimer:

I have received treatment and / or device from The Rothman Institute. I accept this treatment and / or device knowing that I may be personally and fully responsible for any payment, including out of pocket, deductible and non-payment from my insurance. I understand that while I may be provided an estimate of my financial responsibility, the actual amount due may differ and I will be held liable for any difference. I understand that prior authorization from my insurance is not a guarantee of payment. Medicare patients - I have received the Medicare Supplier Standards.

I understand my physician prescribed this device, and I accept this treatment protocol.

Return Policy: Products may be returned if under warranty and are considered a covered repair. Excessive wear, neglect or abuse of a product will not be covered by the manufacturer. Returns are not accepted on custom fabricated devices. Returns are not accepted on any item after seven days of receipt.

Patient's Signature: Ezekiel Sennard Date: 10/23/13

Reason for Appointment:

Measurement
Delivery
Follow-up

Date of onset: _____

Billing:

Insurance Co: Aetna

Effective Date:

Patient Education:

Verbal
Product inserts / Vendor
Warranty

Eligibility Contact:

Deductible: 03,000
Deductible Met: Y N

Copay/Coins.: 10%
Out of Pocket: 8,000
OOP Met: Y N

Precert Req: Y / N

Auth #:

Patient's Estimated Responsibility:
Amount Pd: _____ Balance: _____

8776.40

Goals:

ADL's
Immobilization
Return to activity

I have checked the prescribed orthosis for quality and appropriateness for my patient.

Practitioner's signature: Dawn Fierst Printed name: Dawn Fierst

MEDICAL BILL



- PO BOX 757910
PHILADELPHIA, PA 19175-7910
 For billing questions, call (267) 339-3558
 Office Phone (267) 339-3558

ACCOUNT NAME	Esteban Serrano
ACCOUNT NO.	[REDACTED]
STATEMENT DATE	11/28/2018
INSURANCE PENDING	\$0.00

Total Amount Owed: **\$829.41**

Pay or Inquire about your bill at www.rothmanortho.com. Phone hours: Mon through Thurs 9am - 4pm, Friday 9am - 12pm.

Patient Name	Provider	Voucher
Esteban Serrano	Gattone, Jennifer	[REDACTED]

Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Knee Ortho Adj Jnt Pos (L1833)	\$882.00			\$882.00
11/09/18	Aetna Payment			\$0.00	\$882.00
11/09/18	Aetna Adjustment			-\$52.59	\$829.41
11/09/18	Aetna Transfer				\$829.41

This amount represents your deductible. Please remit payment.

Visit Total **\$829.41**

Payment Options

Mail
Please use pay stub below Online
www.rothmanortho.com

Message

Your prompt payment is greatly appreciated.

You may receive multiple statements due to a transition in billing systems.

TO ENSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE.

658871A (PC2)



PO Box 757910
Philadelphia, PA 19175-7910
PERSONAL & CONFIDENTIAL

ADDRESS SERVICE REQUESTED

10046416.col 1008 10046416
Stat Date: 11/28/2018

Check box and see reverse for change of address/insurance information.

ESTEBAN SERRANO

Due Date	Account Number	Amount Due	Amount Paid
12/28/2018	[REDACTED]	\$829.41	
IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.			
<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER
CARD NUMBER		VERIFICATION #	
CARDHOLDER NAME		EXP. DATE	
SIGNATURE			
Or pay online: www.rothmanortho.com			

MAKE CHECKS PAYABLE TO:

THE ROTHMAN INSTITUTE
PO BOX 757910
PHILADELPHIA, PA 19175-7910

PAIS
Jan 09, 2019



Aetna Life Insurance Company
PO BOX 14079
LEXINGTON KY 40512-4079
*027071*J280EVBA*071015*

Statement date: November 24, 2018

*****SCH 5-DIGIT 19460
12174 1 AV 0-378 52
ESTEBAN E SERRANO

QUESTIONS? Contact us at aetna.com
1-855-521-6853
Or write to the address shown above.

Explanation of Benefits (EOB) - This is not a bill

This statement is called your EOB. It shows how much you may owe, the amount that was billed, and your member rate. It also shows the amount you saved and what your plan paid. Look at this statement carefully and make sure it is correct. If you do owe anything, you will receive a bill from your doctor or health care provider(s). If you have access to the secure member website, you can change your delivery preference, view, print or download your EOBS online anytime.

Track your health care costs

You saved \$1,669.00 by going to a doctor or hospital in the network. That's because we have arranged discounted rates with these providers. The online provider directory can help you find a doctor or other health care professional. Just go to www.aetna.com.

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your provider charged for services.	\$2,094.00
Member rate:	This is the health plan covered amount which may reflect a health plan discount. This may be referred to as the allowed amount or negotiated rate.	\$425.00
Pending or not payable:	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	\$0.00
Deductible:	The amount you pay for covered services before your plan starts to pay.	\$425.00
Coinurance:	When you pay part of the bill and we pay part of the bill. This is the out-of-pocket amount that you may owe.	\$0.00
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	\$0.00
Other health plan:	This is known as coordination of benefits (COB). When a member has more than one health plan, both plans' payments will not be more than the billed amount. See 'Your claims up close' for other plan details.	

Go Green!

Go to your secure member website and turn off your paper EOBS. You'll see them quicker. And thanks, if you're already doing your part to go green!

Your payment summary

Patient	Provider	Your plan paid		You owe or already paid	
		Amount	Sent to	Send date	Amount
Esteban (self)	Oaks Radiology	\$0.00			\$425.00
Total:		\$0.00			\$425.00

Patient	Provider	Your plan paid			You owe or already paid		
		Amount	Sent to	Send date		Amount	
Esteban (self)	William D Emper	\$0.00		\$194.90		\$194.90	
Total:		\$0.00		\$1,024.31		\$1,024.31	

Your claims up close

Claim for Esteban (self) Provider: William D Emper (In-Network)

Received on 10/30/18	Amount billed	Member rate	Pending or not payable (Remarks) 	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
OFFICE VISIT 90203 on 10/23/18	210.00	125.60		125.60					125.60
X-RAY EXAM OF KNEE 73564 on 10/23/18	105.00	69.30		69.30					69.30
Refer to Remarks Section			(1)						
Totals:	315.00	194.90		194.90					\$194.90

 You can find all numbered claim remarks in 'Your Claim Remarks' section.

Claim for Esteban (self) Provider: Reconstructive Orthopaedic (In-Network)

Received on 11/2/18	Amount billed	Member rate	Pending or not payable (Remarks) 	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
KO ADJ JNT POS R SUP PRE OTS L1833 on 10/23/18	882.00	829.41		829.41					829.41
Refer to Remarks Section			(1)						
Totals:	882.00	829.41		829.41					\$829.41

 You can find all numbered claim remarks in 'Your Claim Remarks' section.

Your Claim Remarks

General Remarks:

- (1) Your provider may have sent diagnosis codes with your claim. You may obtain these codes and their meanings by contacting us at the number listed at the top of the first page. We will also provide your treatment codes and their meanings, if they do not appear on this statement. If you have questions about your diagnosis or your treatment, please contact your provider. [H63]

Your benefit balances to date for 1/1/18 to 12/31/18

Family Balances	Annual limit	Amount used	Amount remaining
Medical In Network Out of Pocket Maximum*	\$5,000.00	\$1,122.36	\$3,877.64
Medical Out of Network Out of Pocket Maximum*	\$12,000.00	\$1,122.36	\$10,877.64
Medical In Network Deductible*	\$3,000.00	\$1,122.36	\$1,877.64

*Limit includes both Medical and Pharmacy

A complete list of your benefit balances and plan limits can be found on your secure member website.

A Message about Teladoc

Board certified physicians are available 24/7 to quickly diagnose and treat your routine illnesses. Call 1-855-TELADOC (1-855-835-2362) or log onto www.Teladoc.com/Aetna to request a consult.



ROTHMAN

PO BOX 757910
PHILADELPHIA, PA 19175-7910

For billing questions, call (267) 339-3558
Office Phone (267) 339-3558

MEDICAL BILL

ACCOUNT NAME

Esteban Serrano

ACCOUNT NO.

STATEMENT DATE

10/29/2018

INSURANCE PENDING

\$0.00

Total Amount Owed: \$1,197.00

Pay or inquire about your bill at www.rothmanortho.com. Phone hours: Mon through Thurs 9am - 4pm, Friday 9am - 12pm

Patient Name

Voucher

Esteban Serrano

Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Office Outpatient New 3 (99203)	\$210.00			\$210.00
10/23/18	Radiologic Exam Knee Co (73564)	\$105.00			\$315.00
Visit Total					\$315.00

Patient Name

Voucher

Esteban Serrano

Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Knee Ortho Adj Jnt Pos (L1833)	\$882.00			\$882.00

Payment Options

Message

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Please use pay stub below Online
www.rothmanortho.com

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658871A(PC2)

ROTHMAN
ORTHOPAEDIC INSTITUTE

PO Box 757910
Philadelphia, PA 19175-7910
PERSONAL & CONFIDENTIAL

ADDRESS SERVICE REQUESTED

10046416.co1 1008 10046416
Stmt Date: 10/29/2018

Check box and see reverse for change of address/insurance information.

ESTEBAN SERRANO

Due Date	Account Number	Amount Due	Amount Paid
11/28/2018	[REDACTED]	\$1,197.00	
IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARD NUMBER		VERIFICATION #	
CARDHOLDER NAME		EXP. DATE	
SIGNATURE			
Or pay online: www.rothmanortho.com			

MAKE CHECKS PAYABLE TO:

THE ROTHMAN INSTITUTE
PO BOX 757910
PHILADELPHIA, PA 19175-7910

Billing Details**CONTINUED**

Patient Name	Provider	Voucher			
Esteban Serrano	Emper, William				
Date	Service Details	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
10/23/18	Office Outpatient New 3 (99203)	\$210.00			\$210.00
10/23/18	Radiologic Exam Knee Co (73564)	\$105.00			\$315.00
11/09/18	Aetna Payment			\$0.00	\$315.00
11/09/18	Aetna Adjustment			-\$120.10	\$194.90
11/09/18	Aetna Transfer				\$194.90
11/21/18	Self Pay Credit Card Pa			-\$194.90	\$0.00

This amount represents your deductible. Please remit payment.

Visit Total **\$0.00**

Total Amount Due: **\$829.41**

NEED TO UPDATE YOUR INFORMATION? FILL OUT THE INFORMATION BELOW.

YOUR NAME _____

PRIMARY INSURANCE _____ EFF. DATE _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

PHONE _____ MARITAL STATUS SEPARATED
 SINGLE DIVORCED
 MARRIED WIDOWED

POLICY HOLDER'S ID # _____ GROUP PLAN # _____

YOUR EMPLOYER _____

SECONDARY INSURANCE _____ EFF. DATE _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

POLICY HOLDER'S ID # _____ GROUP PLAN # _____